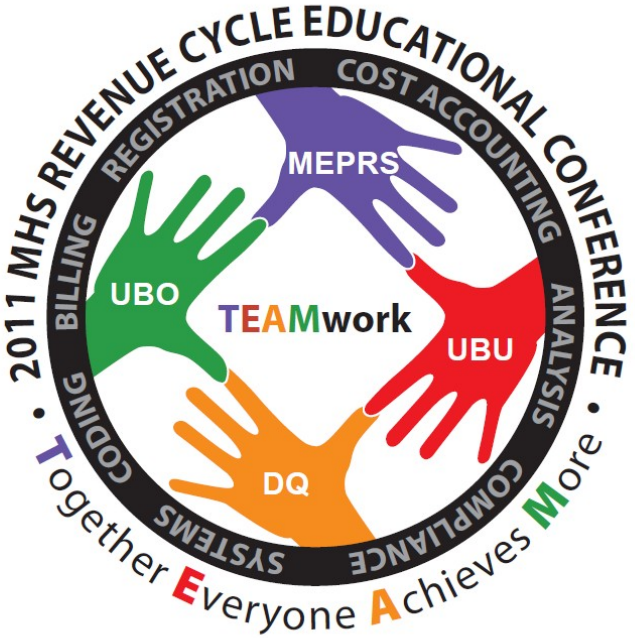


Title: **Capturing POA Through Documentation**

Session: **W-6-1530**

Objectives

- Provide history of Present on Admission (POA)/Hospital Acquired Condition(HAC)
- Define POA requirements and guidelines
- Explain how physician documentation plays a role in capturing POA
- Describe coder's role in accurate POA reporting
- Describe how POA reporting affects coding; impact of MS DRG assignment and reimbursement
- Best practices for POA reporting and implementation

POA Purpose and Definition

- What is POA?
  - POA refers to conditions present at the time the order for inpatient admission is written and includes conditions that are
    - known at the time of admission
    - diagnosed later
    - or develop during an outpatient encounter, including emergency room, observation, or outpatient surgery

POA Purpose and Definition

- What is the purpose of POA?
  - To distinguish between pre-existing conditions present on admission and hospital acquired conditions that develop during an inpatient admission
    - Applies to principal and secondary diagnoses
    - Used for inpatient admissions
    - Identifies hospital acquired complications
    - Identifies co-morbidities

POA Purpose and Definition

- Coordinated Effort for Documentation
  - A coordinated effort between the provider and the coder is essential to complete and accurate documentation, code assignment, and reporting of diagnoses and procedures
  - Documentation from any provider involved in the care and treatment of the patient may be used to determine if condition was present on admission

POA Use and Benefits

- Benefits of POA
  - Identify hospital acquired conditions
  - Reimbursement and financial planning
  - Improve patient quality of care evaluation
  - Identify and measure patient safety efforts
  - Complication and/or mortality rate studies
  - Validity of hospital report cards

POA Reporting Indicators

- Reporting Options and Definitions

Code	Reason for Code
Y	Diagnosis was present at time of inpatient admission. CMS will pay the CC/MCC DRG for those selected HACs that are coded as "Y" for the POA Indicator.
N	Diagnosis was not present at time of inpatient admission. CMS will **not** pay the CC/MCC DRG for those selected HACs that are coded as "N" for the POA Indicator.
U	Documentation insufficient to determine if the condition was present at the time of inpatient admission. CMS will **not** pay the CC/MCC DRG for those selected HACs that are coded as "U" for the POA Indicator.
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission. CMS will pay the CC/MCC DRG for those selected HACs that are coded as "W" for the POA Indicator.
1	Unreported/Not used. Exempt from POA reporting. This code is equivalent to a blank on the UB-04, however; it was determined that blanks are undesirable when submitting this data via the 4010A. CMS will not pay the CC/MCC DRG for those selected HACs that are coded as "1" for the POA Indicator. The "1" POA Indicator should not be applied to any codes on the HAC list. For a complete list of codes on the POA exempt list, see the Official Coding Guidelines for ICD-9-CM. http://www.cdc.gov/nchs/icd/icd9cm_addenda_guidelines.htm

Note: *Coding & Billing Staff - Remember to re-sequence POA indicators when re-sequencing codes prior to billing*

History of POA

- Part of Deficit Reduction Act of 2005
- Required CMS to implement collection and reporting of POA indicators as of October 1, 2007 and
- DRA Requirements as of October 1, 2008
  - Identification of secondary diagnoses that were present on admission for all general acute care hospitals and or other facilities that are subject to law or regulations under the Medicare payment methodology mandating collection of POA information

Reporting Guidelines

- Developed by the Coordinating Parties* and added to ICD-9-CM Official Coding Guidelines October 2006, but they only supplement these guidelines
- They are not intended to replace these guidelines
- Not intended to provide guidance when a condition should be coded
- But do facilitate assignment of POA indicators to final set of diagnoses reported on claim form (UB-04)

* AMA, AHIMA, CMS, and National Center for Health Statistics

Reporting Guidelines

- Issues related to inconsistent, missing, conflicting or unclear documentation must still be resolved by provider
- If condition would not be coded and reported based on UHDDS definitions and current official coding guidelines, then the POA indicator would not be reported
- POA indicator is assigned to principal and secondary diagnoses and the external cause of injury codes
  - Exempt codes do not require a POA indicator; in CCE use “E”

Note: Refer to ICD-9-CM Coding Guidelines for complete list of exempt conditions

POA Requirements and Guidelines

- Timeframe for POA Identification and Documentation
  - No required timeframe when a provider must identify or document a condition to be POA
  - Clinical situations may not be possible for provider to make a definitive diagnosis for a period of time after admission
  - In some cases it may be several days before the provider arrives at a definitive diagnosis
  - Query the responsible physician if documentation is unclear for POA

Assigning POA Indicator

- Condition is on the “exempt from reporting” list
  - Leave POA indicator field blank
    - Only circumstance in which the field may be left blank
    - In CCE assign “E”
    - Note: Refer to ICD-9-CM Coding Guidelines for complete list of exempt conditions
- POA Explicitly Documented
  - Assign “Y” for any condition the provider explicitly documents as POA
  - Assign “N” for any condition the provider explicitly documents as not POA

Assigning POA Indicator

- Conditions diagnosed prior to inpatient admission
  - Assign “Y” for conditions that were diagnosed prior to admission (co-morbidities)
    - Examples:
      - Hypertension
      - Diabetes Mellitus
      - Asthma
      - COPD

Assigning POA Indicator

- Conditions diagnosed during admission but clearly present before admission
  - Assign “Y” for conditions diagnosed during admission
    - Were clearly present but not diagnosed until after admission
  - Assign “Y” for conditions confirmed after admission if at time of admission are documented as
    - Suspected
    - Possible
    - Ruled Out
    - Differential Diagnoses
    - Symptom of condition present on admission

Assigning POA Indicator

- Condition developed during outpatient encounter prior to inpatient admission
  - Assign “Y” to any condition that develops
    - Prior to written order for admission
- Documentation does not indicate whether condition was present on admission
  - Assign “U” when documentation is unclear
    - Query provider first to clarify
    - “U” should not be assigned routinely and only used in limited circumstance – If provider is unsure
- Documentation states that it cannot be determined whether the condition was or was not POA
  - Assign “W” if clinically cannot be determined whether condition was present or not

Assigning POA Indicator

- Chronic condition with acute exacerbation during the admission
  - If combination code identifies both the chronic condition and the acute exacerbation
    - Assign “N” if exacerbation was not present on admission
    - Assign “Y” to the chronic condition
    - Assign “Y” if all parts of the combination code are POA
      - *Example*: *CHF in acute exacerbation*
- Conditions documented as possible, probable, suspected, or ruled out at the time of discharge
    - Assign “Y” if diagnosis was suspected at time of admission
    - Assign “N” if diagnosis was based on symptoms or clinical findings that were not present on admission

Assigning POA Indicator

- Conditions documented as impending or threatened at the time of discharge
  - Assign “Y” if clinical findings or symptoms were POA
  - Assign “N” if clinical findings or symptoms were not POA
- Acute and Chronic Conditions
  - Assign “Y” if acute condition is POA
  - Assign “N” if not POA
  - Assign “Y” even if chronic condition is not diagnosed until after admission
    - If a single code identifies both acute and chronic condition, assign based on combination code POA guidelines

Assigning POA Indicator

- Combination Codes
  - Assign “Y” if all parts of the combination code were present on admission
    - *Example: Patient with Diabetic Nephropathy admitted with Uncontrolled Diabetes*
  - Assign “N” if all parts of the combination code were not present on admission
    - *Examples:*
      - *COPD with acute exacerbation and exacerbation was not present on admission*
      - *Gastric ulcer that does not start bleeding until after admission*
      - *Asthma patient develops status asthmaticus after admission*

Assigning POA Indicator

- Combination Codes
  - Assign “Y” if final diagnosis includes comparative or contrasting diagnoses and both were present or suspected on admission
  - Assign “Y” if the infection code includes a causal organism and signs of infection were present on admission
    - Even though the culture results are not known until after admission
      - *Example: Patient admitted with pneumonia and physician documents Streptococcus as the causal organism a few days later*

Assigning POA Indicator

- Same Diagnosis Code for Two or More Conditions
  - If same ICD-9-CM diagnosis code applies to two or more conditions during the same encounter
    - Assign “Y” if all conditions represented by the single ICD-9-CM code were POA
      - *Example: Bilateral fracture of the same bone, same site and both fractures were present on admission*
    - Assign “N” if any conditions represented by the single ICD-9-CM code was not present on admission
      - *Example: Dehydration with hyponatremia assigned to code 276.1, but only one of these conditions was present on admission*

Assigning POA Indicator

- Obstetrical Conditions
  - Assignment of POA is not affected by whether patient delivers during admission or not
  - Assign “Y” if complication code or obstetrical condition was present at time of admission
    - *Example: Patient admitted in preterm labor*
  - Assign “N” if complication code or obstetrical condition was not present on admission
    - *Examples:*
      - *Fetal distress develops after admission*
      - *Patient sustains 2nd degree laceration during delivery*

Assigning POA Indicator

- Obstetrical Conditions
  - Assign “N” if OB code includes more than one diagnosis and any of the diagnoses identified by the code were not present on admission
    - *Example: Code 642.7x – Pre-eclampsia or eclampsia superimposed on pre-existing hypertension*
  - If OB code includes information that is not a diagnosis, do not consider that information in POA determination
    - *Example: Code 652.1x – Breech or other malpresentation successfully converted to cephalic presentation*
      - Assign “Y” for the breech presentation since cephalic presentation does not represent a diagnosis

Assigning POA Indicator

- Perinatal Conditions
  - Newborns are not considered to be admitted until after birth
    - Assign “Y” for any condition present at birth or that developed in utero
      - Includes conditions that occur during delivery
        - *Examples: Injury during delivery; meconium aspiration; exposure to streptococcus B in the vaginal canal*
    - Assign “N” for conditions that develop after birth
      - *Example: Jaundice diagnosed a day later*
- Congenital Conditions and Anomalies
  - Assign “Y” to all – always considered POA

Assigning POA Indicator

- External Cause of Injury Codes
  - Assign “Y” for any E-codes that occurred prior to inpatient admission
    - *Examples:*
      - *Patient fell out of bed at home*
      - *Patient fell out of bed in emergency room prior to admission (dating and timing of physician orders and notes are critical to determine if injury occurred before admission order was written)*
  - Assign “N” for any E-codes that occurred during inpatient hospitalization
    - *Examples:*
      - *Patient fell out of hospital bed during hospital stay*
      - *Patient had an adverse reaction to medication administered after admission*

POA Examples

- Case #1 – Admission after Ambulatory Patient Visit (APV)

Patient undergoes outpatient surgery. During the recovery period, the patient develops acute renal failure and the patient is subsequently admitted to the hospital as an Inpatient.

Question: Which POA indicator should be reported for the acute renal failure?

a) Y

b) N

c) U

d) W

Note: Answers to cases are provided in background slide

POA Examples

- Case # 2 – Admission after Observation

82 year-old male patient is treated in observation and while in Observation, the patient develops chest pain. Patient also has a history of a CABG and old MI. He is subsequently admitted for treatment of Impending Myocardial Infarction. Final diagnosis "Impending MI."

Question: Which POA indicator should be reported for the Impending Myocardial Infarction?

a) Y

b) N

c) U

d) W

POA Examples

- Case # 3 – Admitted as Inpatient

A patient undergoes inpatient surgery. After surgery, the patient develops a fever an is treated aggressively. The physician's final diagnosis is "possible postoperative infection following surgery."

Question: Which POA indicator is assigned to the "possible postoperative infection"?

a) Y

b) N

c) U

d) W

POA Examples

- Case # 4 – Inpatient – Obstetrics

A 24-year-old pregnant woman is admitted in late pregnancy due to excessive vomiting and dehydration. During the admission patient goes into premature labor.

Question: Which POA indicators are assigned?

a) Y

b) N

c) U

d) W

Documentation for POA

- Again, documentation of POA must be a coordinated effort between the provider and the coder and is essential for
  - Reporting of diagnosis and procedures
  - Code assignment
  - Accurate POA assignment

NOTE: Provider should be queried if diagnoses are not clearly documented as present on admission

Documentation for POA

- It is important to have complete and accurate documentation in the medical record because it is the source document for coding and reporting
- Any privileged provider involved in the care and treatment of the patient may support POA assignment
- Nurses also play an important role with documentation especially with
  - *pressure ulcer staging and BMI*

Documentation for POA

- Documentation Tips for Providers
  - Diagnosis **SPECIFICITY** is a major factor determining POA and accurate documentation is now more important than ever in order to capture the severity of illness, reporting quality and optimal reimbursement
  - Documentation is used to determine POA assignment
    - Impacts MS-DRG assignment
    - RVU and workload capture
    - Documentation improvement efforts
    - Quality of care

Documentation for POA

- Documentation Tips for Providers (cont'd)
  - Provider documentation, again, is critical in coding and reporting POA and MS-DRG assignment
  - Clear and concise identification of conditions that are present or develop after admission is vital
  - Clear documentation will minimize the need to ***query*** to clarify issues with missing, inconsistent, conflicting or ambiguous documentation at the time of admission

Documentation for POA

- Documentation Tips for Providers (cont'd)
  - Be very specific when documenting the condition of the patient
    - *Malnutrition – moderate, severe, protein-calorie, kwashiorkor*
    - *Pneumonia – identify organism*
  - Do document why diagnostic studies are being ordered and their results
    - Patient present with cough, chest x-ray is ordered
      - *Diagnosis: Acute Bronchitis*
  - Do document *abnormal findings* and/or *signs & symptoms* when no definitive diagnosis is found

Documentation for POA

- Documentation Tips for Providers (cont'd)
  - Do note medications and condition for which patient is being treated
    - *Antibiotics for UTI*
    - *Iron for Anemia*
  - Do document chronic/co-morbid conditions
    - *CHF – Systolic/Diastolic, Acute, Chronic, Acute on Chronic, Hypertensive*
    - *COPD – Acute Exacerbation; Acute Bronchitis*
    - *Diabetes Mellitus – Type I, Type II, Uncontrolled*
  - Do include in your Discharge Summary the clinical findings, course in hospital (any complications) and medications provided at discharge

Documentation for POA

- POA Tips for Coders (cont'd)
  - Verify admission order
    - Determination for POA assignment begins at the "time the order for admission is written"
  - Code conditions confirmed during hospital stay and clearly present at time of admission
    - *If suspected, rule out, differential diagnoses, or constitute an underlying cause of a symptom*
    - *If not clear, then assign "N" after querying physician*
  - Code all complications, co-morbidities
  - Query, query, query if documentation is unclear
  - Become familiar with reporting guidelines and acceptable documentation

Documentation for POA

- POA Tips for Coders (cont'd)
- Documents to review for POA assignment
  - Emergency Room Record
    - Look for any signs and symptoms or any condition identified during emergency workup
  - History and Physical
    - Look for patient's condition that may be documented in the exam notes, past medical history component, or any current medications
  - Physician Progress Notes
    - May contain additional findings to the existing condition and include more information on the current condition of the patient

Documentation for POA

- POA Tips for Coders (cont'd)
  - Operative Reports/Admission Forms
    - May include useful information to validate condition as POA
  - Lab and Radiology Reports
    - Search for information in the workup to help determining assignment
      - Note: Lab and x-ray reports alone do not support POA indicators, but the provider documentation does
- In essence – review entire medical record
  - From Admission to Discharge
  - Research difficult/unfamiliar diagnoses or medical terminology
  - Follow Official Coding/MHS Guidelines when coding and reporting diagnoses

Physician Queries

- Provider documentation is key and specificity is essential in correct <u>POA indicator assignment, reimbursement, documentation improvement initiatives, and MS-DRG assignment</u>
  - Query providers if documentation
    - Is ambiguous
    - Inconsistent or missing
    - Cannot determine if symptom/diagnosis is POA
  - Develop a query process
    - Design standard query
    - Establish communication with Case Managers
    - Audit accuracy of POA indicator assignment
    - Work with providers to explain why documentation is important for accurate POA reporting
    - Monitor and trend

Hospital Acquired Conditions

- What is a HAC?
  - Condition that developed during the inpatient hospital stay and affects hospital reimbursement
  - Selected conditions that are:
    - *High cost/and or high volume*
    - *Result in DRG having higher payment when present as secondary diagnosis, and*
    - *Could have been preventable through application of evidenced-based guidelines*

HAC Selected Conditions

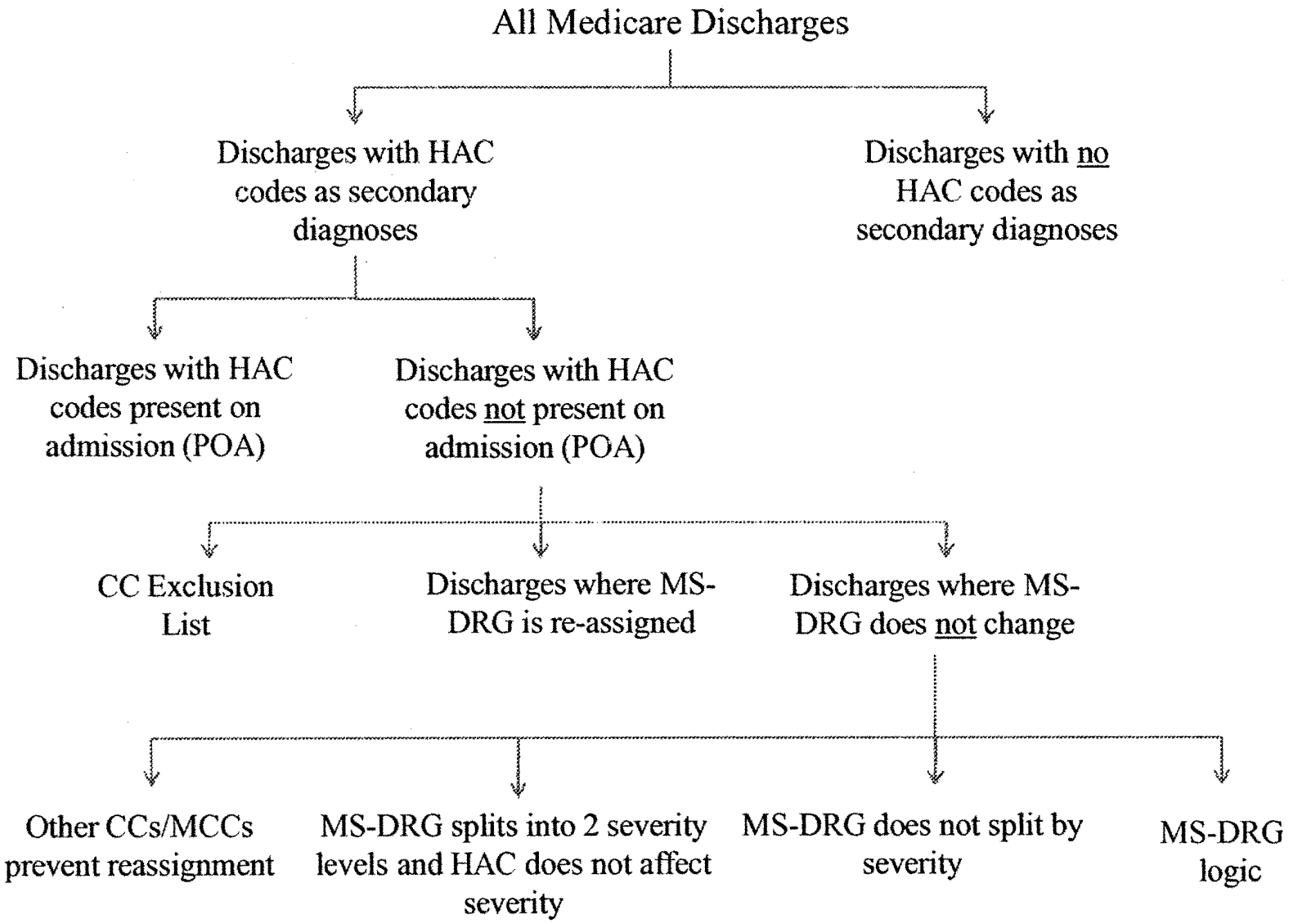
- Conditions selected by CMS

Hospital Acquired Conditions (HACs) as of 08/16/10	
Foreign Object Retained After Surgery	Falls & Trauma
Air Embolism	Infection following certain Orthopedic Procedures
Blood Incompatibility (new codes 999.60-63 & 996.69)	Manifestation of Poor Glycemic Control
Pressure Ulcer Stages III & IV	Infection following Bariatric Surgery for Obesity
Cath-Associated UTI/Vascular Catheter-associated infections	Deep Vein Thrombosis (DVT) and Pulmonary Embolism (PE) following certain Orthopedic Procedures
Mediastinitis following Coronary Artery Bypass Graft (CABG)	

HAC Impact on Reimbursement

- MS-DRG payment to hospitals is reduced if reported conditions are not POA/HAC and will do not count as CC/or MCC unless they are present on admission
- If condition is not POA, then case will be paid as if the diagnosis was not reported
- Payment is reduced if the selected conditions are the only CCs or MCCs present on the case

HAC Impact on Reimbursement



Education Opportunities

- Documentation for capturing POA normally begins with the Emergency Room visit before inpatient admission
- Facilities should
  - Develop & implement POA assessment/checklist
  - Educate providers and clinical staff on POA documentation and capture
    - *Document comprehensive physical exam on admission*
  - Focus capturing conditions for catheter-related infections and UTIs, pressure ulcers – stages
  - Train coding and billing staff
    - Ensure coders understand POA guidelines
    - Ensure billers attach corresponding POA indicator if diagnoses are regrouped

Best Practices

- *Education is the key*
  - Ongoing training and education should be provided to all providers and clinical staff – Embrace provider feedback
  - Identify additional training/education via POA audits
  - Ongoing coder training on POA assignment guidelines
  - Develop POA and query compliance policies for POA/HAC reporting
  - Continuous documentation improvement efforts
  - Collaboration practice between providers, coders, and case managers

Summary

- Understand Present on Admission Guidelines and Reporting; differentiate between conditions present on admission and those that developed after inpatient admission
- Coordinated effort between providers, clinical staff, and coders to ensure accurate documentation and POA reporting
- Develop documentation and POA education initiatives for continuous documentation improvement
- Emphasize importance of physician documentation and how it affects reimbursement, workload, and RVU capture and improve patient quality of care

Questions?

Case Answers

- Case # 1 – Correct Answer: a
  - Assign “Y” for the acute renal failure since it developed prior to a written order for inpatient admission
- Case #2 – Correct Answer: a
  - Assign “Y” for the impending myocardial infarction because the condition was documented as present on admission
- Case #3 – Correct Answer: b
  - Assign “N” for the postoperative infection, since final diagnoses that contain the terms “possible,” “probable,” “suspected,” or “rule out” that are based on symptoms or clinical findings that were not present on admission should be reported as “N”
- Case #4 – Correct Answer: a & b
  - Assign “Y” for the excessive vomiting and the dehydration and “N” for the premature labor

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